

7/1/90

OUTPATIENT HOSPITAL SERVICES: Services are limited to a maximum of \$1,000 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. The \$1,000 limit may be exceeded for any Medicaid-compensable outpatient hospital service if the application of the limitation would result in the services being provided at a higher Medicaid rate elsewhere.

Amendment 93-02  
Effective 1/1/93  
Supersedes NEW

Approval APR 22 1993

7/1/92

EMERGENCY HOSPITAL SERVICES: Same limitations as for  
Outpatient or Inpatient Hospital Services.

Amendment 93-02  
Effective 1/1/93  
Supersedes NEW

Approval ASB 2-6-1993

10/1/90  
(5)

**PHYSICIAN SERVICES:** Limits visits outside the hospital to not more than one per recipient per day per physician (except for emergencies) and initial consultations outside the hospital to one per medical specialty per recipient per medical condition per year (except for emergencies). A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation or treatment of a patient's illness or problem. Also limits one physician visit per recipient per month in all types of long term care facilities (except for emergencies). Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity. Excludes clinically unproven procedures and cosmetic surgery. Sterilization procedures which meet federal requirements and abortion procedures meeting federal requirements are allowed. Health screening examinations for non-EPSDT recipients 21 years of age and older are limited to one per recipient per year. Health screening examinations are provided under EPSDT for EPSDT participants.

Elective surgical procedures require prior authorization or EPSDT screening for inpatient hospital services. For purposes of the plan, elective surgery is defined as those surgical procedures that can be safely deferred without:

1. Threatening the life of the recipient, or
2. Causing irreparable physical damage, or
3. Resulting in the loss or serious impairment of a bodily function, or
4. Resulting in irretrievable loss of growth and development.

Medicaid program medical consultant staff will make individual patient decisions as appropriate regarding whether a patient's procedure meets the above criteria on either a prior or postauthorization basis.

Amendment 93-21  
Effective 4/1/93  
Supersedes 93-20

**SEP 20 1993**

Approval

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

ATTACHMENT 3.1-A  
Page 3  
CMB No.: 0938-

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of  
limitations, if any.  
☐ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health  
agency or by a registered nurse when no home health agency exists in the  
area.

Provided: ☐ No limitations ☒ With limitations\*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With limitations\*

c. Medical supplies, equipment, and appliances suitable for use in the  
home.

Provided: ☐ No limitations ☒ With limitations\*

\*Description provided on attachment.

TN No. 91-50

Supersedes

TN No. 90-59

Approval Date

OCT 6, 1992

Effective Date

10/1/91

HCFA ID: 7986E

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY N

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations\*

☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations\*

☐ Not provided.

\*Description provided on attachment.

TN No. 91- 50

Supersedes

TN No. NEW

Approval Date OCT 6 1992

Effective Date 10/1/91

HCFA ID: 7986E

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: ☐ No limitations ☒ With limitations\*

- 2.a. Outpatient hospital services.

Provided: ☐ No limitations ☒ With limitations\*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

☒ Provided: ☐ No limitations ☒ With limitations\*

☐ Not provided.

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: ☐ No limitations ☒ With limitations\*

3. Other laboratory and x-ray services.

Provided: ☐ No limitations ☒ With limitations\*

\*Description provided on attachment.

TN No. 92-40

Supersedes Approval Date JUL 30 1993

TN No. 92-39

Effective Date 10/1/92

HCFA ID: 7986E

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
Provided:      No limitations X With limitations\*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*
- 4.c. Family planning services and supplies for individuals of child-bearing age.  
Provided:      No limitations X With limitations\*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.  
Provided:      No limitations X With limitations\*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).  
Provided:      No limitations X With limitations\*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.  
Provided:      No limitations X With limitations\*

\* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
(7-1-85)  
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders  
(provided by or under the supervision of a speech pathologist or  
audiologist).

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

\*Description provided on attachment.



AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided. (6-1-75)

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided. (7-1-80)

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided. (7-1-80)

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided. (7-1-80)

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

\*Description provided on attachment.

TN No. 93-57

Supersedes

TN No. 85-8

Approval Date

7-3-96

Effective Date 10/1/93

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations\*  
☒ Not provided.

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations\*  
☐ Not provided.

b. Nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations\*  
☒ Not provided.

\*Description provided on attachment.